MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (x) No
Requestor's Name and Address Dr. W 2436 I-35 E. South, Suite 336 Denton, Texas 76205	MDR Tracking No.: M4-03-4671-01 TWCC No.: ___ Injured Employee's Name: ___
Respondent's Name and Address Liberty Mutual Insurance Company Box 28	Date of Injury: ___ Employer's Name: ___ Insurance Carrier's No.: 949298015

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
03/22/02	**04/18/02**	**97799-CP-75**	**$740.00**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

The carrier has failed to make proper reimbursement for this service stating "M" fee schedule reduction.

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent's position statement was untimely.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

CPT code 97799-CP is an unlisted procedure requiring DOP.

Rule 133.307(g)(3)(D) requires the requestor to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. The requestor did not submit documentation that indicates that their charges were fair and reasonable in the form of redacted EOBs from other carriers. Therefore, based on this information additional reimbursement is not recommended for dates of service 03/22/02 through 04/18/02.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
				Total Left Column:			$0.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Michael Bucklin	12/13/04
	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____